Body Composition Improvement Program
Pre-Participation Questionnaire

Name _____ Last Four of SS#_____

Phone: Duty_____ Home_____ Cell _____

E-mail (other than global, if applicable)_____

Squadron/Unit_____

What type of follow-up appointment do you prefer? Please check one.

_____ Individual _____Small Group

How often would you like to receive feedback from your nutrition counselor?
_____ Weekly
_____ Every other week
_____ Monthly (minimum requirement)

Please circle any of the following weight/fitness-related conditions that you may have:

High Blood Pressure High Cholesterol Level

High Triglyceride Level Diabetes or High Blood Sugar

Are you taking any medications for the above conditions? Please list.
_____
_____

Do you take any vitamins, minerals, herbs, or any other food or nutritional supplement?
_____Yes _____No. If yes, please list:
_____
_____

Note: Nutritional Medicine Personnel attach CHCS lab print out to questionnaire.